a natural approach to the roots of your health

LITTLE OAK wellness

Hello,

Thank you for choosing Little Oak Wellness for your rehabilitation needs! We are excited to meet you at your first appointment!

It sometimes feels like there is a lot of information to go through in the first session. We will give you ample time to tell your story and express your concerns and goals for wellness.

Attached to this email is a questionnaire to help you tell your story! We have designed this questionnaire based on the most up-to-date research on the contributing factors of pain and pelvic health.

Completing this questionnaire helps me look at every problem from a whole-person perspective. This will allow me to look at your issue(s) from all angles and increases the efficiency and effectiveness of our work together. Your pain, pelvic health, and symptoms may arise from many different social, emotional, and physical factors.

Some have reported that it feels overwhelming to fill out the questionnaire since it does cover your life story and symptoms in detail. Rest assured; completion of the questionnaire is completely voluntary. If you do not complete it due to your comfort level, it will not affect the quality of care that you receive. Please answer only the questions you are comfortable with.

If you have any personal questions you would like to address before your first appointment, please feel free to email me personally at sam@littleoakwellness.ca.

Thank you for partnering with us on your journey towards better health!

-Samantha Del Bigio (MPT, B.Sc, Licenced in Pelvic Floor Physiotherapy)

Women Pelvic Floor Intake Form

Date:
First and Last Name:
Age:

- **Presenting problems/when did this start? _____**
- **Occupation _____**
- **How did you hear about us? _____**
- **Have you ever seen a physician or healthcare provider for the problem you are coming in for today?** ☐Yes ☐No
    - **If yes, who? _____**
    - **Treatment Provided? _____**
- **Diagnosis/Reports _____**
- **Hobbies/activities _____**

Gynecological History

Please complete the following sections if they apply to you & you are comfortable answering:

- **What age did your period start? _____**
- **Is your cycle regular?** ☐Yes ☐No **Is your bleeding heavy?** ☐Yes ☐No
- **How long is your cycle? _____**
- **Do you have pain with your period?** ☐Yes ☐No
    - **If yes, when? _____**
- **Do you use tampons or a menstrual cup?** ☐Yes ☐No
    - **If yes, do you have pain with insertion?** ☐Yes ☐No
- **Do you have excessive discharge?** ☐Yes ☐No
- **Are you sexually active?** ☐Yes ☐No
    - **If yes, do you have pain with intercourse?** ☐Yes ☐No ☐Sometimes
- **Do you have pain after sexual activity?** ☐Yes ☐No ☐Sometimes
- **Do you have pain with penetration?** ☐Yes ☐No ☐Sometimes

- **If yes, is the pain with insertion or deep penetration? _____**

- **Do you use lubrication?** ☐Yes ☐No ☐Sometimes
  - **If yes, what type? _____**
- **Do you participate in anal sex?** ☐Yes ☐No ☐Sometimes
  - **If yes, do you have pain with anal penetration?** ☐Yes ☐No ☐Sometimes
  - **Do you use birth control?** ☐Yes ☐No **If yes, birth control type:**
- **# of pregnancies: _____ # of live births: _____Age of child(ren): _____**
- **Weight of heaviest baby: _____ # of C-sections: _____ # of vaginal deliveries: _____**
- **Length of pushing stage: _____ Hours**
- **Did you have an epidural?** ☐Yes ☐No **Forceps used?** ☐Yes ☐No
- **Vacuum-assisted delivery?** ☐Yes ☐No **Episiotomies?** ☐Yes ☐No
- **Tears?** ☐Yes ☐No **Grade of tear:**
- **Are you currently breastfeeding?** ☐Yes ☐No
- **Did you experience any post-natal complications?** ☐Yes ☐No
  - **If yes, please specify: _____**
- **During my labour(s) and delivery, I felt supported and cared for:**

  ☐All of the time ☐Some of the time ☐A little bit ☐Not at all

- **Were there times when the baby was or seemed to be in danger during labour/delivery?** ☐Yes ☐No
- **Do you suffer, or have you suffered form post-partum depression?** ☐Yes ☐No
- **Have you gone through menopause?** ☐Yes ☐No
  - **If yes, when? _____**
- **Do you suffer from vaginal dryness?** ☐Yes ☐No
- **Do you use vaginal moisturizer?** ☐Yes ☐No
- **Have you had hormone replacement therapy?** ☐Yes ☐No
  - **If yes, when? _____**
- **Do you have feelings of heaviness/pressure in your vagina?** ☐Yes ☐No
- **Have you ever been told you have a prolapse?** ☐Yes ☐No
    - **If yes, what type: _____**

Have you had any of the following procedures? If so, please provide the approximate date

APPENDECTOMY	**LAPAROSCOPY**	**TVT-TVT (O)**
MESH PROCEDURE	**COLOSTOMY**	**HERNIA REPAIR**
BARTHOLIN CYST	**CYSTOSCOPY**	**GALLBLADDER REMOVAL**
PROLAPSE REPAIR	**HYSTERECTOY**	**URODYNAMICS**
BOWL RESECTION	**COLONOSCOPY**	**HERMORRHOID SURGERY**
OTHER		

Bladder Symptoms

Did you have problems with your bladder during childhood? ☐Yes ☐No ☐Sometimes

Do you have leakage associated with sneezing, coughing, running, and/or laughing? ☐Yes ☐No ☐Sometimes

Do you have leakage during intercourse? ☐Yes ☐No ☐Sometimes

Do you ever feel a strong urge to void but don't leak? ☐Yes ☐No ☐Sometimes

Do you ever rush to the toilet when you feel a strong urge? ☐Yes ☐No ☐Sometimes

- **If yes, how often?** _____

Do you sometimes not make it to the toilet? ☐Yes ☐No ☐Sometimes

- **If yes, how often?** _____

What triggers bring on the urgency? ☐Washing hands ☐Drinking a liquid ☐Hearing water run ☐Other

Do you have pain where your bladder fills? ☐Yes ☐No ☐Sometimes

Does your pain improve when you void? ☐Yes ☐No ☐Sometimes

Do you have to strain in order to empty your bladder? ☐Yes ☐No☐Sometimes

Do you have difficulty starting your urine stream? ☐Yes ☐No ☐Sometimes

Do you have dribbling after you get up from the toilet? ☐Yes ☐No ☐Sometimes

Do you sit on the toilet? ☐Yes ☐No ☐Sometimes

Do you have incomplete emptying when you void and feel like you have to go again? ☐Yes ☐No ☐Sometimes

Do your bladder problems cause you to leak at night? ☐Yes ☐No ☐Sometimes

Does your incontinence fluctuate with your cycle? ☐Yes ☐No ☐Sometimes

Does your inconsistence require you to wear pads? ☐Yes ☐No ☐Sometimes

- **If yes, how often and which type?** _____

Do you void during the day more than the average person? ☐Yes ☐No ☐Sometimes (5-7 times per day?)

- **If yes or sometimes, how often?** _____

Do you need to get up at night to void? ☐Yes ☐No ☐Sometimes

- **If yes or sometimes, how many times?** _____

Fluid Intake in 24 hours

- **Number of cups of water per day _____**
- **Number of cups of coffee per day _____**
- **Number of cups of tea per day _____**
- **Number of cups of other fluids per day _____**
- **Number of alcoholic drinks per day/week/month _____**

Digestion and Bowl Function

What is the frequency of your bowel movements? _____

Do you regularly feel the urge to move your bowels? ☐Always☐Sometimes☐Never

Do you have control over your bowels to make it to the toilet? ☐Always☐Sometimes☐Never

Do you have constipation? ☐Always☐Sometimes☐Never

Do you strain to have a bowel movement? ☐Always☐Sometimes☐Never

Do you splint or assist to pass stool? ☐Always☐Sometimes☐Never

Do you have loose stools/diarrhea? ☐Always☐Sometimes☐Never

Do you have incomplete emptying? ☐Always☐Sometimes☐Never

Do you have pain with a bowel movement? ☐Always☐Sometimes☐Never

Do you have pain after a bowel movement? ☐Always☐Sometimes☐Never

Does it take longer than 5 minutes to have a bowel movement? ☐Always☐Sometimes☐Never

Do you experience bloating? ☐Always☐Sometimes☐Never

Do you experience a physical change in abdominal girth when your bowels are full? ☐Always☐Sometime☐Never

Do you have blood in your stool? ☐Always☐Sometimes☐Never

In your opinion, is your fibre intake: ☐Too low ☐Adequate ☐Too High

Do you regularly use? ☐Laxatives ☐Stool Softeners ☐Natural Products

Have you ever been diagnosed with or think you have?

- **Irritable bowel syndrome? When? _____**
- **Ulcerative Colitis? When? _____**
- **Crohn's Disease? When? _____**
- **Celiac Disease? When? _____**

Medical History

- **Urinary tract infections?** ☐Yes ☐No **How often? _____**

  Last infection? _____
- **Yeast Infections?** ☐Yes ☐No **How often? _____**

  Last infection? _____
- **Antibiotics Recently?** ☐Yes ☐No **Last Dose?_____** **Probiotics?** ☐Yes ☐No
- **Cranberry Supplementation?** ☐Yes ☐No
- **Do you smoke?** ☐Yes ☐No
  - **Number of packs/days _____**
- **Chronic Cough?** ☐Yes ☐No **Do you get blood in your urine?** ☐Yes ☐No
- **Do you have any food allergies or sensitivities? _____**
  - **Other allergies (including latex) _____**
- **Do you exercise?** ☐Yes ☐No
  - **Type _____**
  - **Frequency _____**
- **Low back problems?** ☐Yes ☐No **Chronic?** ☐Yes ☐No
- **Mid back problems?** ☐Yes ☐No **Chronic?** ☐Yes ☐No
- **Neck problems?** ☐Yes ☐No **Chronic?** ☐Yes ☐No
- **Have you ever been treated for depression?** ☐Yes ☐No
  - **If yes, what treatment? _____**
  - **Was it effective?** ☐Yes ☐No
- **Have you ever been treated or anxiety?** ☐Yes ☐No
  - **If yes, what treatment? _____**

- **Was it effective?** ☐Yes ☐No
- **Have you ever been diagnosed with a mental health condition?** ☐Yes ☐No
    - **If yes, please specify: _____**

<u>Do you have any other medical conditions? Check those that apply</u>

Arthritis ☐	**Hearth Attack ☐**	**Diabetes ☐**
Osteoporosis ☐	**Pacemaker ☐**	**Thyroid Problems ☐**
Scoliosis ☐	**Angina ☐**	**Glandular Problems ☐**
Bone/Joint Issues ☐	**High Blood Pressure ☐**	**Skin Conditions ☐**
Muscular Disorder ☐	**Low Blood Pressure ☐**	**Cancer ☐**
Disease of Internal Organs ☐	**Stroke ☐**	**Xray Therapy ☐**
Other Heart Problems ☐	**Breathing Disorder ☐**	**Fainting ☐**
High Dose Steroid Therapy ☐	**Multiple Sclerosis ☐**	**Varicose Veins ☐**
Other Neurological Disorders ☐	**Dizziness ☐**	**Epilepsy ☐**

- **Previous fractures, surgeries, or hospitalizations _____**

  _____
- **Please list all medications you are currently taking (including vitamins/supplements)**

  _____

  _____

  _____

Pelvic Floor Physiotherapy Consent Form

I acknowledge and understand that I have been referred for evaluation and treatment of pelvic floor dysfunction, which includes but is not limited to: urinary/fecal incontinence, bladder/ bowel function difficulties, sexual function difficulties, painful scars after childbirth or surgery, persistent low back/hip/thigh pain, or pelvic pain conditions.

I understand that to evaluate my condition, it may be necessary, initially and periodically, to have my therapists perform an internal pelvic floor muscle examination. This examination is performed by observing and/or palpating the perinea! region including the vagina and/or rectum. This evaluation will assess skin condition, reflexes, muscle tone/length/strength/ endurance, scar mobility, and function of the pelvic floor. I understand that I will be required to disrobe for the internal exam, and that appropriate draping's and coverings will be provided. I will have the opportunity to give or revoke my consent at each treatment session.

Treatment may include, but is not limited to the following: observation, palpation, use of vaginal weights, vaginal or rectal sensors for biofeedback and/or electrical stimulation, ultrasound, heat, cold, stretching and strengthening exercises, soft tissue and/or joint mobilization, and educational instruction.

I acknowledge that I have informed my physiotherapist of all my health issues and concerns (past and present) including malignant and inflammatory diseases, history of urinary tract infections, medication use, IUDs and other implants, sexually transmitted infections, and pregnancy. I have also disclosed other treatment options, including other health care providers that I am currently seeing or have seen for this condition.

Potential benefits: I may experience a reduction in symptoms and an improvement in my ability to perform daily activities. I may experience an improvement in muscular strength, endurance, flexibility, and/or awareness. I should gain a greater knowledge about managing my condition and the resources that are available to me.

Potential risks: I may experience a temporary aggravation of pain/discomfort, minor bleeding/ spotting, skin reaction/irritation, nausea, light-headedness, or an emotional response/anxiety. These effects are usually temporary and I agree to contact my physiotherapist or physician if they do not subside after 1-3 days.

Cooperation with treatment: I understand that in order for therapy to be effective, I must come as scheduled unless there are unusual circumstances that prevent me from attending therapy. I agree to cooperate with and carry out the home program assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

No warranty: I understand that the physical therapist cannot make any promises or guarantees regarding a cure for improvement in my condition. I understand my therapist will share with me her opinions regarding potential results of physical therapy for my condition and will discuss all treatment options with me before I consent to treatment.

Signing below indicates that I understand the above information.

Date: Click or tap here to enter text.
First and Last Name: Click or tap here to enter text.
Signature: Click or tap here to enter text.

Assessment Questionnaires **CSI: Part A**

	Never	Rarely	Sometimes	Always
I Feel Un-Refreshed When I Wake Up In The Morning	☐	☐	☐	☐
My Muscles Feel Stiff And Achy	☐	☐	☐	☐
I Have Anxiety Attacks	☐	☐	☐	☐
I Grind Or Clench My Teeth	☐	☐	☐	☐
I Have Problems With Diarrhea/Constipation	☐	☐	☐	☐
I Need Help In Performing My Daily Activities	☐	☐	☐	☐
I Am Sensitive To Bright Lights	☐	☐	☐	☐
I Get Tired Easily When I Am Physically Active	☐	☐	☐	☐
I Feel Pain All Over My Body	☐	☐	☐	☐
I Have Headaches	☐	☐	☐	☐
I Feel Discomfort In My Bladder/Or Burning When I Urinate	☐	☐	☐	☐
I Do Not Sleep Well	☐	☐	☐	☐
I Have Difficulty Concentrating	☐	☐	☐	☐
I Have Skin Problems Such As Dryness, Itchiness Or Rashes	☐	☐	☐	☐
Stress Makes My Physical Symptoms Get Worse	☐	☐	☐	☐
I Feel Sad/Depressed	☐	☐	☐	☐
I Have Low Energy	☐	☐	☐	☐
I Have Muscle Tension In My Neck And Shoulders	☐	☐	☐	☐
I Have Pain In My Jaw	☐	☐	☐	☐

Certain Smells Such As Perfumes, Make Me Feel Dizzy And Nauseated	☐	☐	☐	☐
I Have To Urinate Frequently	☐	☐	☐	☐
My Legs Feel Uncomfortable And Restless When I Am Trying To Sleep	☐	☐	☐	☐
I Have Difficulty Remembering Things	☐	☐	☐	☐
I Suffered Trauma As A Child	☐	☐	☐	☐
I Have Pain In My Pelvic Area	☐	☐	☐	☐

CSI: Part B: Have you been diagnosed by a doctor with any of the following disorders?

	No	**Yes**	**Diagnosed**
1. Restless Leg Syndrome	☐	☐	☐
2. Chronic Fatigue Syndrome	☐	☐	☐
3. Fibromyalgia	☐	☐	☐
4, Temporomandibular Joint Disorder (TMJ)	☐	☐	☐
5. irritable bowel syndrome	☐	☐	☐
6. Multiple Chemical Sensitivities	☐	☐	☐
7. Neck Injury (Including Whiplash)	☐	☐	☐
8. Headaches (Migraine Or Tension)	☐	☐	☐
9. Anxiety Or Panic Attacks	☐	☐	☐
10. Depression	☐	☐	☐

On a scale of 1-10, please rate how bothersome the problems you are presenting with are for you

1 2 3 4 5 6 7 8 9 10

On a scale from 1-10, please rate how hopeful you are that you will be able to correct these problem(s) 1 2 3 4 5 6 7 8 9 10

DASS Questionnaire

Please read each statement and rate a number, 0, 1, 2, or 3, which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

0 – It did not apply to me at all

1 – Applied to me to some degree or some of the time

2 – Applied to me a considerable degree or a good part of the time

3 – Applied to me very much or most of the time

1.	**I found it hard to wind down**	☐0 ☐1 ☐2 ☐3 **S**
2.	**I was aware of dryness of my mouth**	☐0 ☐1 ☐2 ☐3 **A**
3.	**I couldn't seem to experience any positive feelings at all**	☐0 ☐1 ☐2 ☐3 **D**
4.	**I experienced breathing difficulty (eg, excessively rapid breathlessness in the absence of physical exertion)**	☐0 ☐1 ☐2 ☐3 **A**
5.	**I found it difficult to work up the initiative to do things**	☐0 ☐1 ☐2 ☐3 **D**
6.	**I tend to over-react to situations**	☐0 ☐1 ☐2 ☐3 **S**
7.	**I experienced trembling (eg, in the hands)**	☐0 ☐1 ☐2 ☐3 **A**
8.	**I felt that I was using a lot of nervous energy**	☐0 ☐1 ☐2 ☐3 **S**
9.	**I was worried about situations in which I might panic and make a fool of myself**	☐0 ☐1 ☐2 ☐3 **A**
10.	**I felt that I had nothing to look forward to**	☐0 ☐1 ☐2 ☐3 **D**
11.	**I found myself getting agitated**	☐0 ☐1 ☐2 ☐3 **S**
12.	**I found it difficult to relax**	☐0 ☐1 ☐2 ☐3 **S**
13.	**I felt down-hearted and blue**	☐0 ☐1 ☐2 ☐3 **D**
14.	**I was intolerant of anything that kept me from getting on with what I was doing**	☐0 ☐1 ☐2 ☐3 **S**
15.	**I felt I was close to panic**	☐0 ☐1 ☐2 ☐3 **A**
16.	**I was unable to become enthusiastic about anything**	☐0 ☐1 ☐2 ☐3 **D**
17.	**I felt I wasn't worth much as a person**	☐0 ☐1 ☐2 ☐3 **D**
18.	**I felt that I was rather touchy**	☐0 ☐1 ☐2 ☐3 **S**
19.	**I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)**	☐0 ☐1 ☐2 ☐3 **A**
20.	**I felt scared without any good reason**	☐0 ☐1 ☐2 ☐3 **A**
21.	**I felt that life was meaningless**	☐0 ☐1 ☐2 ☐3 **D**

ISI

This is a questionnaire about sleep. For each question, please select the number that best describes your answer. Please rate the CURRENT (in the last two weeks) SEVERITY (of your sleep problems.

Insomnia Problem	None	Mild	Moderate	Severe	Very Severe
1. Difficulty falling asleep					
2. Difficulty staying asleep					
3. Problems waking up too early					

How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?

Very Satisfied	Satisfied	Moderately Satisfied	Dissatisfied	Very Dissatisfied

How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life?

Not at all Noticeable	A Little	Somewhat	Much	Very Much Noticeable

How WORRIED/DISTRESSED are you about your current sleep problem?

Not at all Worried	A Little	Somewhat	Much	Very Much Worried

To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) CURRENTLY?

Not at all Interfering	A Little	Somewhat	Much	Very Much Interfering

If you struggle with any TYPE of PAIN as part of your symptoms, please fill out the following questionnaires

If you DO NOT have Pain, you can stop filling out this questionnaire at this point.

PCS Questionnaire

Everyone experiences painful situations at some point in their lives. Such experiences may include headaches, tooth pain, joint or muscle pain. People are often exposed to situations that may cause pain such as illness, injury, dental procedures or surgery.

We are interested in the types of thoughts and feelings that you have when you are in pain. Listed below are 13 statements describing different thoughts and feelings that may be associated with pain.

Using the following scale, please indicate the degree to which you have these thoughts and feelings when you experience pain, **O = not at all 1 = to a slight degree 2 = to a moderate degree 3 = to a great degree 4 = all the time**

(H)	**I worry all the time about whether the pain will end**	**0 1 2 3 4**
(H)	**I feel I can't go on**	**0 1 2 3 4**
(H)	**It's terrible and I think it's never going to get any better**	**0 1 2 3 4**
(H)	**It's awful and I feel that it overwhelms me**	**0 1 2 3 4**
(H)	**I feel I like can't stand it anymore**	**0 1 2 3 4**
(M)	**I become afraid that the pain will get worse**	**0 1 2 3 4**
(M)	**I keep thinking of painful events**	**0 1 2 3 4**
(R)	**I anxiously want the pain to go away**	**0 1 2 3 4**
(R)	**I can't seem to keep it out of my mind**	**0 1 2 3 4**
(R)	**I keep thinking about how much it hurts**	**0 1 2 3 4**
(R)	**I keep thinking about how badly I want the pain to stop**	**0 1 2 3 4**
(H)	**There's nothing I can do to reduce the intensity of my pain**	**0 1 2 3 4**
(M)	**I wonder whether something serious will happen**	**0 1 2 3 4**

Vulvar Pain Functional Questionnaire

These are statements about how your pelvic pain affects your everyday life. Please check one box for each item below, choosing the one that best describes your situation. Some of the statements deal with personal subjects. These statements are included because they will help your health care provider design the best treatment for you and measure your progress during treatment. Your responses will be kept completely confidential at all times.

1. Because of my pelvic pain

☐ 3 I can't wear tight-fitting clothing like pantyhose that puts any pressure over my painful area.

☐ 2 I can wear closer fitting clothing as long as it only puts a little bit of pressure over my painful area.

☐ 1 I can wear whatever I like most of the time, but every now and then I feel pelvic pain caused by pressure from my clothing.

☐ 0 I can wear whatever I like; I never have pelvic pain because of clothing.

2. My pelvic pain

☐ 3 Gets worse when I walk, so I can only walk far enough to move around in my house, no further.

☐ 2 Gets worse when I walk. I can walk a short distance outside the house, but it is very painful to walk far enough to get a full load of groceries in a grocery store.

☐ 1 Gets a little worse when I walk. I can walk far enough to do my errands, like grocery shopping, but it would be very painful to walk longer distances for fun or exercise.

☐ 0 My pain does not get worse with walking; I can walk as far as I want to

☐ 0 I have a hard time walking because of another medical problem, but pelvic pain doesn't make it hard to walk.

3. My pelvic pain

☐ 3 Gets worse when I sit, so it hurts too much to sit any longer than 30 minutes at a time.

☐ 2 Gets worse when I sit. I can sit for longer than 30 minutes at a time, but it is so painful that it is difficult to do my job or sit long enough to watch a movie.

☐ 1 Occasionally gets worse when I sit, but most of the time sitting is comfortable. ☐0 My pain does not get worse with sitting, I can sit as long as I want to.

☐ 0 I have trouble sitting for very long because of another medical problem, but pelvic pain doesn't make it hard to sit.

4. Because of pain pills I take for my pelvic pain

☐ 3 I am sleepy and I have trouble concentrating at work or while I do housework.

☐ 2 I can concentrate just enough to do my work, but I can't do more, like go out in the evenings.

☐ 1 I can do all of my work, and go out in the evening if I want, but I feel out of sorts.
☐ 0 I don't have any problems with the pills that I take for pelvic pain.

☐ 0 I don't take pain pills for my pelvic pain.

5. Because of my pelvic pain

☐ 3 I have very bad pain when I try to have a bowel movement, and it keeps hurting for at least 5 minutes after I am finished.

☐ 2 It hurts when I try to have a bowel movement, but the pain goes away when I am finished.

☐ 1 Most of the time it does not hurt when I have a bowel movement, but every now and then it does.

☐ 0 It never hurts from my pelvic pain when I have a bowel movement.

6. Because of my pelvic pain
☐ 3 I don't get together with my friends or go out to parties or events.
☐ 2 I only get together with my friends or go out to parties or events every now and then.

☐ 1 I usually will go out with friends or to events if I want to, but every now and then I don't because of the pain.

☐ 0 I get together with friends or go to events whenever I want, pelvic pain does not get in the way

7. Because of my pelvic pain

☐ 3 I can't stand for the doctor to insert the speculum when I go to the gynecologist.

☐ 2 I can stand it when the doctor inserts the speculum if they are very careful, but most of the time it really hurts.

☐ 1 It usually doesn't hurt when the doctor inserts the speculum, but every now and then it does hurt.

☐ 0 It never hurts for the doctor to insert the speculum when I go to the gynecologist.

8. Because of my pelvic pain

☐ 3 I cannot use tampons at all, because they make my pain much worse.

☐ 2 I can only use tampons if I put them in very carefully.
☐ 1 It usually doesn't hurt to use tampons, but occasionally it does hurt.

☐ 0 It never hurts to use tampons.

☐ 0 This question doesn't apply to me, because I don't need to use tampons, or I wouldn't choose to use them whether they hurt or not.

9. Because of my pelvic pain

☐ 3 I can't let my partner put a finger or penis in my vagina during sex at all.
☐ 2 My partner can put a finger or penis in my vagina very carefully, but it still hurts.

☐ 1 It usually doesn't hurt if my partner puts a finger or penis in my vagina, but every now and then it does hurt.

☐ 0 It doesn't hurt to have my partner put a finger or penis in my vagina at all.

☐ 0 This question does not apply to me because I don't have a sexual partner.

☐ 0 Specifically, I won't get involved with a partner because I worry about pelvic pain during sex.

10. Because of my pelvic pain

☐ 3 It hurts too much for my partner to touch me sexually even if the touching doesn't go in my vagina.

☐ 2 My partner can touch me sexually outside the vagina if we are very careful
☐ 1 It doesn't usually hurt for my partner to touch me sexually outside the vagina, but every

now and then it does hurt
☐ 0 It never hurts for my partner to touch me sexually outside the vagina

☐ 0 This question does not apply to me because I don't have a sexual partner.

☐ 0 Specifically, I won't get involved with a partner because I worry about pelvic pain during sex.

11. Because of my pelvic pain

☐ 3 It is too painful to touch myself for sexual pleasure.
☐ 2 I can touch myself for sexual pleasure if I am very careful.
☐ 1 It usually doesn't hurt to touch myself for sexual pleasure, but every now and then it does hurt.

☐ 0 It never hurts to touch myself for sexual pleasure.

☐ 0 I don't touch myself for sexual pleasure, but that is by choice, not because of pelvic pain.